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Original Communication

Firearm-assisted suicide: Legislative, policing and clinical concerns

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ABSTRACT

Until recent years the Republic of Ireland had one of the most restrictive regimes on firearms access with the Irish police (An Garda Siochana) consistently refusing to grant certificates for a wide range of guns including handguns, high calibre rifles and shotguns capable of holding more than three cartridges. In 2004 the High Court ruled that this policy was without legislative backing and since then the police began to issue certificates for firearms where the applicant is not disentitled under law from possessing a gun. Set against this backdrop, this paper explores the consequences of liberal gun regimes in the context of access to firearms by those suffering from mental illness and who pose a threat of parasuicide or suicide. Consideration is given to experiences in other jurisdictions and international research on firearm suicide prevention. Finally some recommendations for changes in legislation, policy and protocol in the Irish context are presented.

1. Introduction

This paper deals with key issues relating to access to firearms in Ireland by those suffering from mental illnesses and who currently, or have in the past, posed a threat of self-harm. It is offered in the context of a growing awareness of the need to restrict access among those displaying risk-indicators and for legislative reform in the area of firearms certification.

One of the central tenets of the discussion that follows is that reducing this form of firearms-related threat can only be achieved within a system that controls and restricts access to firearms within society in general. Legislation that prohibits and restricts access to highly lethal firearms, forces owners to store guns in purpose-built quality-controlled cabinets, and promotes the establishment of shooting clubs that can store firearms and provide competence training to owners, should lead to a reduction in a range of deaths and injuries currently being experienced in Ireland. It is only within this form of gun-control regime that specific measures to deal with firearm-assisted suicide can be effectively designed and implemented.

2. International experience

International studies have reported a positive direct relationship between levels of firearms ownership and prevalence of firearms-assisted suicide in societies, with those societies with higher concentrations of firearms ownership also experiencing the highest rates of firearms suicides.[1] Others have noted that the risk of dying from suicide is higher in homes where guns are stored than in other homes.[2–5] There have also been a plethora of studies that have reported significant decreases in firearms suicides in the wake of more draconian firearms legislation.[6–9]

The best example of the latter occurred in Australia. The Australian Federal Government instructed all States and Territories to reform firearms legislation in the wake of an attack by Martin Bryant in Port Arthur, Tasmania, in 1996 during which 35 people died. Bryant had used a variety of automatic weapons during the attack and was clearly psychologically unstable at the time. Whilst the legislation enacted varies somewhat across States and Territories, all areas prohibited ownership of certain types of firearms, including semi-automatic rifles and shotguns. Those in possession of such guns at the time of the new legislative position were required to surrender them to the authorities and were financially compensated by the State. In total 643,726 weapons were surrendered.[10]

New protocols for applying and processing licenses were also introduced. In Tasmania, for instance, an applicant now has to demonstrate that he/she has completed a firearms safety course, has secure storage facilities and is a 'fit and proper person'.[11] On the latter, the applicant is asked if they have ever required treatment for 'mental/emotional problems' and an affirmative reply leads to a request for further information.[11] In other States the applicant is required to provide a character reference and consent to the police contacting medical advisors should they feel this is necessary. Psychologists, medical practitioners and other health

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care providers are also legally obliged to inform the police, in writing, of the identity of any individual who they suspect possesses a firearm but is unsuitable to do so.

The impact of the new legislation on firearms-related death and injury in Tasmania was the subject of an official audit. The audit reported a decrease in gun-related crimes, thefts of firearms and gunshot accidents and injuries in the wake of the new legislation. Of particular relevance here, firearms-assisted suicides also decreased significantly, accounting for 46% of all suicides prior to legislative change and 19% of suicides in the post-1996 period.[12] Audits in other jurisdictions that had introduced more draconian legislation reported similar trends.[6–9]

3. The Irish experience

According to the National Suicide Research Foundation there were 8547 suicides recorded in Ireland between 1980 and 2003. Almost 80% of these victims were male ($n = 6714$). The most common suicide method recorded was hanging, accounting for 3403 deaths, followed by drowning (2089) and poisoning (1841). There were differences across gender, however, with females more likely to take their own lives through 'poisoning' and drowning, and males through hanging.

Shooting was the fourth most common method of suicide amongst both males and females in the 23 year period reviewed with a total of 725 firearm-assisted suicides occurring (Max = 50, Min = 14, Mean = 30, SD = 8.9). Male victims of suicides were statistically more likely to have used a firearm in committing suicide than female victims ($M = 681$, $F = 44$, $X^2 = 111.2$, $df = 1$, $p \leqslant .001$) and most firearms-assisted suicides occurred between the ages of 15 and 24 ($n = 250$) and 25 and 44 (267). Firearm-assisted suicides were also more closely associated with being resident in a rural environment ($X^2 = 132$, $df = 1$, $p \leqslant .001$).

In contrast to other jurisdictions, firearms-assisted suicides do not appear to be on the increase in Ireland. As illustrated in Fig. 1, despite an increase in overall suicides over the last 25 years, firearms suicide levels have remained relatively stable, as have poisoning and drowning. Most of the variance in suicide levels over that period is accounted for by the dramatic increase in hangings since 1990 ($r = .98$, $p \leqslant .0001$).

According to the Firearms Licensing Unit of the Irish Police (An Garda Síochána), there are in the region of 233,120 certified firearms in Ireland at present, with approximately 15,000 additional applications processed each year. In the main these certificates pertain to firearms licensed as having a sporting or hunting purpose and 'self-defence' is not recognised as a legitimate motivation for seeking a certificate. In line with this policy position, the Gardaí consistently refused to issue licenses for handguns until the mid 2000s when this practice was relaxed as a result of a number of judicial review proceedings.

4. The legal position

Legislation governing the use and possession of firearms in Ireland is contained in a number of Acts and amending Acts including the Firearms Acts 1925–1971 and, most recently, the Criminal Justice Act 2006. In addition to this legislative framework there are a number of statutory instruments that deal with the matter. The existence of these provisions in a myriad of statutes and statutory instruments has led to difficulties in interpretation. Recently, Charleton J. stated '...that the piecemeal spreading over multiple pieces of legislation of the statutory rules for the control of firearms is undesirable. Codification... is almost as pressing a need as it is in the area of sexual violence'.[13] While the Criminal Justice Act 2006 amended and substituted existing firearms provisions, many of the relevant provisions have yet to come into force.

The current procedure for the application, certification and revocation of licenses as it pertains to mental illness and firearms-assisted suicide will be considered here. An applicant applies to the local police superintendent for a firearms certificate. The Firearms Act 1925 states that before issuing the certificate the superintendent must be satisfied that the applicant 'is not a person declared by this Act to be disentitled to hold a firearm certificate'.[14]

Section 8 lists those disentitled to hold a firearm, which includes a person of 'unsound mind'. The term 'unsound mind' is not defined in the legislation however it is a term traditionally used in reference to long-stay patients involuntarily detained in psychiatric units under the Mental Treatment Acts 1945–1966. However, these Acts have been repealed by the Mental Health Act 2001, which does not make reference to persons of 'unsound mind'. Based on communiqué with the Dept. of Justice, Equality and Law Reform and those from the legal profession, it would appear that there is no legal definition of 'unsound mind'. Section 37 of the Criminal Justice Act 2006 amended Section 8 of the Act, however it did not amend or substitute this term to reflect legislative changes in the area of mental health.

Concern about this has not arisen in Ireland primarily because of the low numbers of firearms-assisted suicides that occur here.

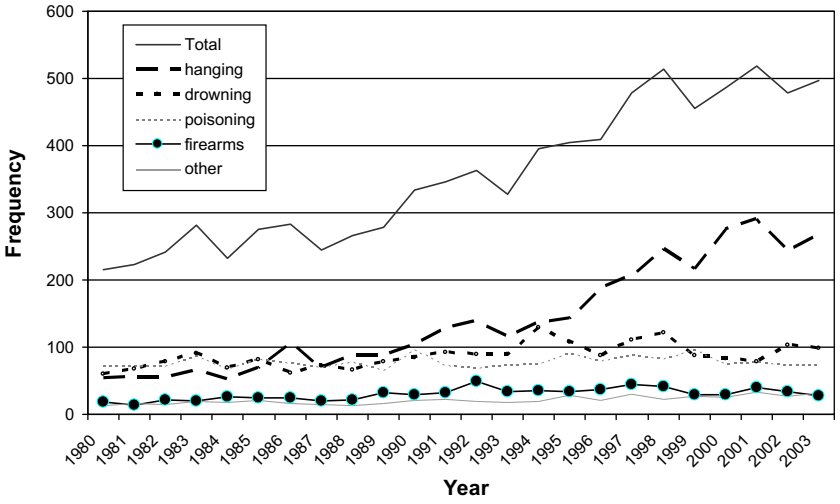

Fig. 1. Suicides in Ireland from 1980 to 2003 by method.

There is growing concern, however, in the context of a more liberal firearms climate. Up until 2004, the Gardaí operated a stringent practice in the licensing of firearms within the legislative framework. From 1972 to 2004 rifles above .22 calibre and handguns were licensed in only the most exceptional circumstances.[13] In the last number of years this stringent policy, implemented through the decisions of Garda superintendents on firearm license applications, has been the subject of a significant number of judicial review proceedings. In 2004 a sport shooting enthusiastic challenged the Gardaí's refusal to license a Toz-35 pistol by means of judicial review in the High Court.[15] The case was unopposed by the State and the handgun was subsequently certified in re-application.

Between 2004 and 2008 there were a number of similar challenges, most finding in favour of the applicant.[16,17] By September 2008 there were 1842 handguns licensed.[16,18] and at that time it appeared that handguns would become a permanent feature of the firearms climate.

Concern about access to firearms by those suffering from mental illnesses predated these events however. The need for reform was highlighted by Barr J. in the Tribunal of Inquiry into the facts and circumstances surrounding the fatal shooting of John Carthy at Abbeylara, Co Longford on 20th April 2000 (hereinafter 'the Barr Tribunal'). The Barr Tribunal examined a siege situation in April 2000 during which Mr. Carthy discharged numerous shots in the direction of the Gardaí and was subsequently shot dead by the Emergency Response Unit.[19]

The Barr Tribunal also considered Mr. Carthy's access to a firearm. In 1998 Gardaí in Abbeylara were approached by a member of the local community who alleged that John Carthy, a 32-year old with a history of bi-polar depression, was in possession of a shotgun, was mentally unstable, and had made threats against children and posed a threat to her husband. Mr. Carthy denied the allegations but the local Gardaí decided to take possession of the firearm pending an investigation. This investigation failed to uncover evidence that such threats were ever made and appear to be based on hearsay.[19]

Subsequent to this Mr. Carthy attended a meeting with the local Garda Superintendent and was informed that the gun would be returned if he could satisfy the Gardaí that he did not pose a threat to society. Mr. Carthy approached his local GP for a letter to this effect, but this was not forthcoming and so he requested the same document from his treating consultant psychiatrist. The psychiatrist was unaware of the allegations being levelled against his patient and provided this letter, stating that should the situation change his general practitioner would make contact with the Gardaí. Mr. Carthy's GP was not informed of this, nor was he consulted or his thoughts on the issue sought. The gun was later returned.[19]

Barr J. made a number of observations in relation to John Carthy's access to a firearm. In particular he noted that there is no onus on a firearms applicant, or applicant seeking a renewal of a firearms certificate, to provide evidence that they are not of 'unsound mind' or to furnish information on their medical or physical fitness. Nor is a declaration required, in the form of a signature, that the applicant is not disentitled to possess a firearm. He also expressed concern at the lack of guidelines for Garda superintendents to assist them in the exercise of their administrative powers.

There has been significant movement to introduce reform in this area. The amendments to the Firearms Acts contained in the Criminal Justice Act 2006, when commenced, will go some way towards bringing Ireland in line with systems adopted elsewhere and with the recommendations of the Barr Tribunal. The Criminal Justice Act 2006 permits the Commissioner of the Garda Siochana to issue guidelines in relation to the certification process and the application of the provisions of the legislation.[20] Further, it substitutes Section 4 of the Firearms Act 1925 listing conditions to be fulfilled when a superintendent is issuing a firearm certificate.[20] Section 32(d) requires an applicant to provide secure accommodation for the firearm and ammunition. On making an application, a person must provide written consent to permit an enquiry in relation to the applicant's medical history from a health professional and must provide the name and address of two referees who can attest to the applicant's character.[20] 'Health professional' is defined as any doctor or psychiatrist registered under any enactments governing the profession concerned or a clinical psychologist. The applicant must also provide proof of competence in the use of the firearm.[20] Section 32 has yet to come into force.

There is further evidence that the State is acting to minimise the risk posed by liberal firearms legislation here. In late 2008 the Minister for Justice, Equality and Law Reform announced his decision to bring forward legislation banning access to all handguns save those used in Olympic target shooting. Earlier in the year the Firearms (Restricted Firearms and Ammunition) Order had specified the firearms that persons are permitted to possess and declares all other firearms restricted. It also contains a list of prohibited ammunition.[21] This is a positive development and should eliminate the difficulties encountered as a result of the reluctance of the Gardaí to issue certificates for certain types of firearms.

5. Discussion

The central argument being put forward here is that efforts to reduce firearms-related death and injury among those suffering from mental illnesses, and reducing the possibility that low-frequency high-casualty incidents might occur in the future, require a two-tiered response. Tier one involves passing legislation and delegated legislation that imposes a regime of restricted access to firearms and promotes the safe storage and use of guns within society as a whole. The international experience is that restrictive policies on firearms ownership and access can lead to decreases in levels of gun-related deaths and injuries. In response, many jurisdictions have introduced more conservative firearms policies.

Ireland moved from a situation where an extremely conservative position in relation to handguns existed prior to 2004, to a very liberal system where handguns could easily be licensed and acquired, with no provisions for 'carrying a concealed weapon' or safe storage. Restrictions on firearms and ammunition have now been put in place through statutory instrument and should result in a reversion to the conservative position adopted prior to 2004. However, while the Criminal Justice Act 2006 requires that the firearm and ammunition be kept in secure accommodation, a term that is undefined and can be interpreted in many ways, the relevant provision has not yet come into force. Compulsory safe storage reduces access to firearms by both criminal elements and members of the certificate-holders immediate family. Again, and as reviewed above, there is considerable evidence that safe storage of weapons can lead to reductions in accidental and purposeful harm. To that end, the relevant provision of the Criminal Justice Act 2006 must be brought into force and the Commissioner of the Garda Siochana should exercise his statutory power to issue guidelines detailing the standard of secure accommodation necessary to discharge this legislative requirement.[20]

The second tier of incident prevention should deal specifically with preventing access to firearms by those suffering from mental disorders and who pose a threat of self-harm or harm to others. The Barr Tribunal explored a number of potential initiatives, one of which involves the firearm applicant providing a medical certificate that contains information relating to his emotional and psychological suitability to possess a firearm. Drawing on an earlier report by Lord Cullen into the Dunblane incident in the United Kingdom during which 16 children and one adult were killed, Justice Barr noted that this investigation had concluded that General

Practitioners simply did not have the expertise to make a risk assessment in this context. Cullen had in fact gone further and stated that '[i]t is clear that forensic psychiatrists and clinical psychologists doubt their own ability to predict violent behaviour [and] a generalist such as the applicant's [GP] is even less able to reach soundly-based judgement as to his potential for violence'.[22] Justice Barr concluded that mandatory medical reports were 'unworkable from an administrative point of view'.[19]

The problem here is that the Barr Tribunal appears to have focused on medical reports that contain a formal risk assessment conducted by the medical practitioner. Yet the role of the GP, or indeed specialist mental health professional, could stop short of conducting a full risk assessment and involve, instead, a structured questionnaire that seeks factual information only. Responses relating to past history of mental illness, period of ill-health, the nature of the illness and past evidence of a threat of self-harm could be elicited in a checklist format that does not directly seek the opinions of the medical professional. As a best case scenario this would help identify those who have a documented and unequivocal history of severe mental illnesses and self-harm and who are clearly unsuitable to possess a firearm. It would also help Gardaí identify cases that are less clear-cut but merit further consultations with the applicant's medical advisors.

The most salient argument against mandatory medical reporting, however, is the potential for erosion of the 'patient–therapist' relationship. This is a complex issue that merits a paper in its own right, but on a surface level it would appear that the concerns are threefold. First, it is at least possible that some patients in need of medical support may be reluctant to engage with the health services, fearing that this would lead to a refusal of a firearms application or renewal or based on a perceived division of loyalties. Second, some patients may be reluctant to fully disclose the full spectrum or severity of their symptoms to their medical advisors, including self-harm ideation, for the same reason. Third, where a medical report does prompt Gardaí to refuse a certificate the patient may, consciously or unconsciously, blame the medical professional. All three factors significantly impede the assessment, diagnosis and effective treatment of mental ill-health and present an almost insurmountable obstacle to a formal agreement between the Gardaí, applicant and medical practitioners to seek a medical report in the case of each certificate application and renewal.

In testimony before the Barr Tribunal representatives of the medical profession argued against mandatory medical reports stating that the necessary provisions were already present in the Irish Medical Council's Ethical Guide, where a clinician is required to breach patient-privilege where this is judged necessary to protect the interest of the patient or welfare of society. Justice Barr appears to have accepted this argument, suggesting that the best way forward is to update the Ethical Guide with more specific guidelines on reporting at-risk patients.

This, however, falls well short of a concrete provision for preventing access to firearms. Based on discussions with consultant psychiatrists, it is clear that even where evidence of self-harm is present, an examination of methods available, and in particular access to firearms, is unlikely to be conducted (i.e. a formal risk assessment by a forensic psychiatrist). This is even less likely to occur in the more generalist setting of a GP's surgery. In fact there is no evidence of systematic reporting of high-risk cases to the Gardaí, and this is despite the fact that many victims of suicide have a history of parasuicide, that there have been in excess of 450 suicides each year since 1997, and more than 10,000 cases of parasuicide were recorded on the National Para-suicide Register in 2002. There were also 20 cases of self-harm using a firearm recorded on the National Para suicide Register in the period 2002–2004. The reality, therefore, is that current 'ethical' provisions are woefully inadequate in this specific context and that formal protocol is required. Updating the Ethical Guide will do nothing to address the problem at the coalface of incident prevention.

It is argued here that some middle ground needs to be found between mandatory medical reports for all applicants and renewals and the existing vacuum. This can only be attained through a thorough consultation process with the various stakeholders in the area, including patient representative groups, medical practitioners, policy setters and the Gardaí. At this early stage, however, it would appear that there is a strong argument for considering some creative version of mandatory medical reporting and working from this more extreme option to a workable solution.

It is clear that the legislature favoured the approach recommended by Barr J. when considering these issues. The Criminal Justice Act 2006 inserts a new provision into the legislation to permit a superintendent to enquire into the applicant's medical history.[20] This provision was explained by the then Minister for Justice, Equality and Law Reform, Michael McDowell TD, stating that '. . .if a superintendent has any reason to suspect any psychological, psychiatric or medical condition, the applicant in question must supply the necessary information as a precondition of securing the firearm certificate'.[23] There was a general discussion in the Oireachtas [Houses of Parliament] regarding the appropriate approach to be taken. Senator Henry commented that the provision is based on a presumption that a Garda would know that there were medical grounds to require an examination of previous medical history.[24] However, the Minister for Justice argued that this was the most practical approach that could be taken and that requiring all applicants to be assessed in some manner was impractical.[25] It will be interesting to observe the operation of this provision when it is brought into force and the frequency with which the Gardaí utilise it.

At present neither tier of firearm incident prevention is fully effective in Ireland. Until this first tier of prevention has been cemented there is little chance of implementing second-level prevention dealing specifically with self-harm and suicide, and firearms-assisted suicides will continue to form a significant proportion of all suicides in Ireland for the foreseeable future.

Conflict of Interest

The authors of this paper hereby declare that they have no conflict of interest in submitting this paper to the Journal of Forensic and Legal Medicine.

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Ethical Approval

Access to vulnerable populations was not required and ethical approval was not sought or obtained.

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